You can make more money this year!

Sometimes referred to as a cafeteria plan, flex plan, or a Section 125 plan– a Flexible Benefits Plan lets you set aside a certain amount of your paycheck into an account– before paying income taxes. During the year you have access to this account for reimbursement of expenses you regularly pay for, such as healthcare and dependent daycare.

When you use tax-free dollars to pay for these expenses, you realize an increase in your spending power, and substantial tax savings.

Reimbursable Expenses can include:

- Deductibles, Co-pays, and Prescription Drugs
- Expenses not covered by insurance
- Dental Services & Orthodontics
- Eyeglasses, Contacts, Solutions & Eye Surgery
- Weight-loss programs (associated with a specific disease)
- Chiropractic services
- Psychiatric care & Psychologist's fees
- Smoking Cessation programs
- Over-the-counter drugs that are medically necessary like allergy medications or aspirin
- Adult & Child Daycare services
- Adoption Expenses
- And more!

Without the plan	
Gross Earnings	$ 2,000
FICA, Federal, State Taxes	- $500
Insurance Premium	- $100
Health and Day Care Expenses	- $300
Net Earnings	**$ 1,100**

With the plan	
Gross Earnings	$ 2,000
FICA, Federal, State Taxes	- $400
Insurance Premium	- $100
Health and Day Care Expenses	- $300
Adjusted Gross Earnings	$ 1,600
Net Earnings	**$ 1,200**

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STEP 1: Your Options

There are several accounts you can participate in with the Flexible Benefits Plan.

I: Healthcare Reimbursement Account

This account reimburses you for healthcare expenses not covered by insurance. You set aside money, tax-free, through regular payroll deductions. During the year, you can be reimbursed directly from your account for those qualified healthcare services provided that are not covered by insurance.

Common expenses that qualify for reimbursement are-doctor visits, deductibles, co-payments, prescriptions, mental health care, dental services and orthodontics, chiropractor services, eye exams, glasses and contacts.

II: Dependent Care Reimbursement Account

This account reimburses you for daycare expenses for eligible children and adults. Through regular payroll deductions, you set aside part of your income to pay for these expenses on a tax-free basis. To qualify, your dependents must be:

- A child under the age of 13, or
- A child, spouse or other dependent who is physically or mentally incapable of self-care and spends at least 8 hours a day in your household.

Qualified Expenses for reimbursement include—adult and child daycare centers, preschool and before/after school care. Please check with your Employer Benefits Dept. or Consociate • Dansig Customer Service at 1.800.798.2422 for additional restrictions.

PLEASE NOTE: A dependent care credit is available on your annual tax return. Whether or not to participate in the daycare portion of this plan depends on your income, filing status, number of dependents and annual daycare expenses. You will also receive your tax savings throughout the year, rather than once a year when you file your taxes. Contact your plan administrator for further information.

III: Adoption Expense Reimbursement Account

The adoption account reimburses you for eligible expenses incurred in the adoption of a qualified child. These expenses include reasonable and necessary legal adoption fees, court costs, and attorney fees.

A qualifying child is an individual who has not attained the age of 18 as of the time of the adoption or is physically or mentally incapable of caring for himself. A qualifying child does not include the child of an individual's spouse.

IV: Additional Benefit

Your employer may have included benefits in addition to the programs described above. Your Benefits Department will send notification, along with enrollment brochure, if any such additional benefits are being offered at this time.

STEP II: Determining Your Reimbursable Expenses

By completing the following information, you can calculate your annual reimbursable expenses. Take into consideration the services to be provided during the upcoming plan year for you and your dependents.

Healthcare Expenses	
Medical (1)*	
Deductibles	$
Co-payments	$
Doctor Visits	$
Prescriptions	$
Over-the-counter medications	$
Medications	$
Other	$
Total	$
Vision (2)	
Exams	$
Eye Surgery	$
Lenses/Frames	$
Contacts	$
Solutions	$
Other	$
Total	$
Dental (3)*	
Routine Check-ups	$
Fillings/Crowns	$
Orthodontics	$
Other	$
Total	$
Dependent Daycare Expenses	
Children	$
Adults	$
Total	$
Adoption Expense	
Total	$
Other Reimbursable Expenses**	
Total	$

Estimated Annual Expenses and Tax Savings	
Total Healthcare Expenses (add 1 + 2 + 3)	$
Total Dependent Daycare Expenses	$
Total Adoption Expenses	$
Total Other Reimursable Expenses	$
Total Expenses	$
Tax Bracket Percentage (see below)	%
Annual Tax Savings (multiply total expenses by tax bracket percentage)	$
Savings Amount/Paycheck (divide total expenses by number of paychecks you receive each year: 52, 26, 24, 12)	$

Tax Estimate Table

Based on a combination of social security, federal, and state income taxes.

Annual household earnings	Estimated tax rate
Less than $30,000	**25% = .25**
$30,000 to $40,000	**29% = .29**
$40,000 to $70,000	**31% = .31**
Greater than $70,000	**33% = .33**

These tax rates are estimates based on national averages and may not reflect your actual tax rate.

* Cosmetic procedures like teeth bleaching and face lifts are not eligible expenses for reimbursement.

** An "Additional Benefit" may not be offered by your employer. Check with your Human Resources Department

STEP III: Complete the Participation Form

Using the information you calculated in Step II, complete the attached Participation Form and return it to your Benefits Department.

Participation Form for the Flexible Benefits Plan

General Information

Plan year or plan effective date		
Employer name	Date of Birth (Month/Day/Year)	
Employee Name (First, Middle, Last)	Social Security No.	
Department	E-mail	
Home address		
City	State	Zip
Home phone ( )	Work phone ( )	
First payroll effective date	Paycheck frequency	
Number of pay periods remaining in the plan year		

Option I: Healthcare Reimbursement Account Agreement

- ❑ I elect to contribute $_____(before taxes) per pay period, which is $_____per plan year, to fund my account for reimbursement of qualified out-of pocket healthcare expenses not covered under my health and other insurance plans.
- ❑ I decline to participate in this option for this plan year.

Option II: Dependent Daycare Reimbursement Account Agreement

- ❑ I elect to contribute $_____(before taxes) per pay period, which is $_____ per plan year, for funding Reimbursement of qualified dependent daycare expenses. (Maximum amount per calendar year is the lesser of; (1) $5,000 for married filing joint, or $2,500 for married filing separate; (2) your spouse's total annual compensation; or (3)1/2 of your total annual compensation. If you are single, the maximum amount is $5,000.)
- ❑ I decline to participate in this option for this plan year.

Option III: Adoption Expense Reimbursement Account

- ❑ I elect to contribute $_____(before taxes) per pay period, which is $_____per plan year, for funding Reimbursement of qualified adoption expenses. (Maximum amount per child adopted is adjusted annually. If Additional expenses are incurred for the adoption of this child, a credit may be available to you. Please see your tax advisor for maximums or further details.)
- ❑ I decline to participate in this option for this plan year.

Option IV: Additional Benefit (please insert description provided by your Benefits Department)

_____

- ❑ I elect to contribute $_____(before taxes) per pay period, which is $_____per plan year, for funding reimbursement of this additional benefit outlined by my Benefits department.*
- ❑ I decline to participate in this option for this plan year.

* Do not complete this section unless you have received instructions from your Benefits department.

My employer and I agree that my taxable income will be reduced each pay period by the amounts set forth in this agreement. I understand that I may change my election in the event of certain changes in my status. Prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. Any qualified expenses that are submitted by me will be reimbursed to me on a tax-free basis. Any contributions that are not used during the plan year may not be paid to me in cash or used in a later plan year. A copy of the Summary Plan Description is available upon request.

Employee Signature_____ Date _____